Mental Health Counselor Associate License Application Packet

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Important Social Security Number Information:

You are required by state and federal law to provide a social security number with your application. If you do not have a social security number at the time you send in this application, contact the Customer Service Center at 360.236.4700 for more information.

A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted.

In order to process your request:

Mail your application with initial documentation and your check or money order payable to:

Department of Health
PO Box 1099
Olympia, WA 98507-1099

Send other documents not sent with initial application to:

Mental Health Counselor Associate
Credentialing
PO Box 47877
Olympia, WA 98504-7877

Contact us:

360.236.4700

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Application Instructions Checklist

Important background check Information: Washington State law authorizes the Department of Health to obtain fingerprint-based background checks for licensing purposes. This check may be through the Washington State Patrol and the Federal Bureau of Investigation (FBI). This may be required if you have lived in another state or if you have a criminal record in Washington State. This would be at your own expense.

All information should be typed or printed clearly in blue or black ink. It is your responsibility to submit the required forms.

☐ **Application Fee.** This fee is **non-refundable**. You can check the online **fee page** for current fees.

☐ **Do you hold a credential in Washington State?** Check yes or no. If you do hold a credential in Washington, please provide your license number.

☐ **1. Demographic Information:**
Social Security Number: You must list your social security number on your application. Please call the Customer Service Center at 360.236.4700 if you do not have one.

Legal Name: List your full name: first, middle, and last.

Definition of legal name: "Legal name" is the name appearing on your official certificate of birth or, if your name has changed since birth, on an official marriage certificate or an order by a court. The court must have the legal authority to change your name. We may ask you to prove your legal name. If you use any name other than your legal name on this form, your application may be denied.

Birth date: Provide the month, day, and year of your birth.

Birth place: Provide the city, state, and country where you were born.

Address: List the address we should use to send any information about your license. Be sure to include the city, state, zip code, county, and country. This will be your permanent address with the Department of Health until we have been notified of a change. See **WAC 246-12-310**.

Phone, Fax and Cell Numbers: Enter your phone, fax and cell numbers, if you have them.

Email: Enter your email address, if you have one.

Other Name(s): Indicate whether you are known or have been known under any other names. If you have a name change, you must notify the Department of Health in writing. You must include proof of this change. See **WAC 246-12-300**.

☐ **2. Personal Data Questions:**
All applicants must answer the same personal data questions. They are focused on your fitness to practice the essential skills of this profession.

If you answer “yes” to any questions in this section, you must provide an appropriate explanation. You must also provide the documentation listed in the note after the questions. If you do not provide this, your application is incomplete and it will not be considered.

- Question 5 includes misdemeanors, gross misdemeanors and felonies. You do not have to answer yes if you have been cited for traffic infractions. You can get copies of court records through the county courthouse where the conviction, plea, deferred sentence, or suspended sentence was entered.
- Another jurisdiction means any other country, state, federal territory, or military authority.

☐ **3. Education:**
List your educational preparation. Attach additional completed pages if you need more space.

Approved educational programs include:

a. Any college or university accredited by an accreditation body recognized by the Council for Higher Education Accreditation (CHEA) or its successor.

b. Applicants who have completed a masters or doctoral program accredited by the Council for Accreditation of Counseling and Related Education Programs (CACREP) will be credited with 50 hours postgraduate supervision and 500 hours postgraduate experience.

Transcripts:
Have your school send official school transcripts directly to the Mental Health Counselor Associate Credentialing.

☐ **4. Course Content Identification for Licensed Mental Health Counselor Associates:** Behavioral science in a field relating to mental health counseling includes a core of study relating to counseling theory and counseling philosophy. Either a counseling practicum, or a counseling internship, or both, must be included in the core of study. Exclusive use of an internship or practicum used for qualification must have incorporated supervised direct client contact. This core of study must include seven content areas from the entire list in subsections (1) through (17) of **WAC 246-809-221**, five of which must be from content areas in subsections (1) through (8) of this subsection.

☐ **5. Other License, Certification, or Registration:**
List all states, including Washington, where credentials are or were held. Specifically list credentials granted by examination, endorsement, or grandparented.

An Out-of-State Credential Verification Form is enclosed and must be sent to each state you listed. Enter your full name and birth date at the top of the form so the state can identify you. Also contact each state board listed for any fees they may charge you for processing the verification.

☐ **6. Declaration Working Toward Licensure:**
Declare that you are working toward licensure as a Mental Health Counselor.

☐ **7. AIDS Education and Training Attestation:**
Read the AIDS education and training attestation. AIDS training may include self-study, direct patient care, courses, or formal training. A minimum of four hours is required. Course content can be found in **WAC 246-12-270**.

☐ **8. Applicant's Attestation:**
You must sign and date this for us to process the application.

We appreciate your interest in obtaining a credential. You will be notified in writing if further documentation is required. If your application is incomplete, you will be mailed or emailed a letter regarding the deficiencies.

- The application is considered incomplete if requested information is left blank. Put N/A or place a line through a section instead of leaving it blank.
- You must keep your address up to date in order to receive a courtesy renewal notice. Any renewal postmarked or presented to the department after midnight on the expiration date is late.

To receive notifications regarding the profession, please join our List-Serv at: **List-Serv.**

Notice to Spouses and Registered Domestic Partners of Military Personnel Transferring to Washington

Under a new state law, a spouse or registered domestic partner of military personnel transferring to Washington may receive his or her health professional license more quickly. In order for us to do this, please complete the additional form found at **the military resources page** and include supporting documentation with your application.

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Washington State Department of Health

Background Check Stamp Here

Date Stamp Here

Revenue: 0207030000

Mental Health Counselor Associate License Application

Do you hold a credential in Washington State? ☐ No ☐ Yes

If yes, license # _____

1. Demographic Information

Social Security Number (If you do not have a social security number, see instructions)	☐ Male ☐ Female

Name	First	Middle	Last

Birth date (mm/dd/yyyy)	**Place of birth**		
	City	State	Country

Address			
City	State	Zip Code	County
Country			

Phone (enter 10 digit #)	Fax (enter 10 digit #)	Cell (enter 10 digit #)

Email address:

Mailing address if different from above address of record

City	State	Zip Code	County
Country			

Note: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information on file with the department.

Have you ever been known under any other name(s)? ☐ Yes ☐ No
If yes, list name(s):

Will documents be received in another name? ☐ Yes ☐ No
If yes, list name(s):

For Office Use Only

License # _____ Issue Date_____

2. Personal Data Questions

	Yes	No
1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach explanation.	☐	☐

"Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disabilities, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

If you answered yes to question 1, explain:

1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.

1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

Note: If you answered "yes" to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.

The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.

2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain.	☐	☐

"Currently" means within the past two years.

"Chemical substances" include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism?	☐	☐
4. Are you currently engaged in the illegal use of controlled substances?	☐	☐

"Currently" means within the past two years.

Illegal use of controlled substances is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.

5. Have you **ever** been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction?	☐	☐

Note: If you answered "yes" to question 5, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered.

To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.

2. Personal Data Questions (Cont.)

	Yes	No
a. Are you now subject to criminal prosecution or pending charges of a crime in any state or jurisdiction	☐	☐

Note: If you answered "yes" to question 5a, you must explain the nature of the prosecution and/or charge(s). You must include the jurisdiction that is investigating and/or prosecuting the charges. This includes any city, county, state, federal or tribal jurisdiction. If charging documents have been filed with a court, you must provide certified copies of those documents. If you do not provide the documents, your application is incomplete and will not be considered.

b. If you answered "yes" to question 5a, do you wish to have decision on your application delayed until the prosecution and any appeals are complete?	☐	☐
6. Have you ever been found in any civil, administrative or criminal proceeding to have:		
a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes?	☐	☐
b. Diverted controlled substances or legend drugs?	☐	☐
c. Violated any drug law?	☐	☐
d. Prescribed controlled substances for yourself?	☐	☐
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", please attach an explanation and provide copies of all judgments, decisions, and agreements?	☐	☐
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority?	☐	☐
9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority?	☐	☐
10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession?	☐	☐

3. Education

List the graduate school(s) you attended, month, year, and major of the degree. Request your transcripts from the graduate school(s) you attended, and have the graduate school send **directly** to the Department of Health, Mental Health Counseling Associate Credentialing.

Graduate School	From (mm/dd/yy)	To (mm/dd/yy)	Degree and Major

4. Course Content Identification for Licensed Mental Health Counselor

Requirement: A masters or doctoral degree in mental health counseling or a related field with the substantial equivalent in subject area.

Subject content includes a core of study relating to counseling theories, counseling philosophy, counseling practicum, counseling internship, and should incorporate content in professional ethics and law and shall include at least five content areas (1) through (17) of this subsection and at least two additional content areas from the entire list.

Content Area	Course #	Course Title
1) Assessment / diagnosis		
2) Ethics / Law		
3) Counseling individuals		
4) Counseling groups		
5) Counseling couples and families		
6) Developmental psychology (may be child, adolescent, adult or life span)		
7) Abnormal psychology/psychopathology		
8) Research and evaluation		
9) Career development counseling		
10) Multicultural concerns		
11) Substance / chemical abuse		
12) Physiological psychology		
13) Organizational psychology		
14) Mental health consultation		
15) Developmentally disabled persons		
16) Abusive relationships		
17) Chronically mentally ill		

5. Other License, Certification, or Registration

List all states, including Washington, where credentials are or were held.

State/ Jurisdiction	License/Certification/Registration Type	License/Certification/Registration		Method Licensed		
		Year Issued	Number	Exam	Endorse.	Grandparented

6. Declaration Working Toward Licensure

I declare that I am working toward licensure as a Mental Health Counselor.

Applicant's Initials	Date

7. Aids Education and Training Attestation

I certify I have completed the minimum of four hours of education in the prevention, transmission and treatment of AIDS, which included the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations.

I understood I must maintain records documenting said education for two years and be prepared to submit those records to the department if requested. **I understand that should I provide any false information, my license may be denied, or if issued, suspended or revoked.**

☐ School curriculum

☐ Employer/Other

Applicant's Initials	Date

8. Applicant's Attestation

I,_____, declare under penalty of perjury under the laws of the state of
(Name of Applicant)

Washington that the following is true and correct:

- I am the person described and identified in this application.
- I have read **RCW 18.130.170** and **RCW 18.130.180** of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local, or foreign government agencies.

I understand I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated _____ at _____
(mm/dd/yyyy) (City, State)

by: _____
(Original Signature of Applicant)

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Washington State Department of Health
Mental Health Credentialing
PO Box 47877
Olympia, WA 98504-7877
360.236.4700

Out-of-State Credential Verification

Applicant Name: _____ Birth date: _____
mm/dd/yyyy

I, _____, Secretary of _____,

hereby certify that _____
Official Name of Board

was granted state ☐ Registration ☐ Certificate ☐ License

Number: _____ to practice _____

in the State of _____ on the _____ day of _____, 20_____.

Legal/Disciplinary Action: ☐ Yes ☐ No

If Yes, explain: _____

_____

_____

On the basis of: _____

_____

Did applicant take and pass the NBCC Exam?

☐ Yes ☐ No Passing Score:

☐ Yes ☐ No 100 hours immediate postgraduate supervision with an approved licensed mental health practitioner or equally qualified licensed mental health practitioner.

☐ Yes ☐ No 3000 hours supervised postgraduate experience with approved licensed mental health practitioner or equally qualified licensed mental health practitioner.

☐ Yes ☐ No 1200 hours must be direct counseling with individuals, couples, families or groups.

☐ Yes ☐ No 36 months full time counseling with a qualified licensed mental health counselor.

Status of License: ☐ Current Expiration Date: _____

☐ Expired Date: _____

S E A L

_____
Official Name of Board Phone (enter 10 digit #)

_____
Secretary

_____
Date Certification Prepared

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Washington State Department of Health
Mental Health Credentialing
PO Box 47877
Olympia, WA 98504-7877
360.236.4700

Approved Supervisor Verification
Mental Health Counselor Associate

To the Supervisor:

Please review **WAC 246-809-234**. To supervise a license mental health counselor associate, you must hold a license without restrictions that has been in good standing for at least two years.

You must not be a blood or legal relative or cohabitant of the license associate, license associate's peer, or someone who has acted as the license associate's therapist within the last two years.

Prior to the commencement of any supervision you shall provide the license associate this declaration, stating that you have met the requirements of **WAC 246-809-234** and that you qualify as an approved supervisor.

As an approved supervisor, I attest that I have completed the following:

A minimum of fifteen clock hours of training in clinical supervision obtained through:

- A supervision course; or
- Continuing education credits on supervision; or
- Supervision of supervision; or
- Or any combination of these; and

And twenty-five hours of experience in supervision of clinical practice

I attest that I will gain full knowledge of the supervisor's practice activities including:

- Practice setting
- Record keeping
- Financial management
- Ethics of clinical practice
- A backup plan for coverage

Declaration of Supervision—must be completed by Supervisor and provided to license candidate prior to the commencement of supervision in accordance with **WAC 246-809-234**.

I, _____ a licensed _____ in the
Name of Supervisor

State of _____ with license number _____ attests to _____
Name of License Candidate

that I have read and met all the requirements in connection with **WAC 246-809-234**.

_____
Signature of Supervisor

_____
Date

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RCW/WAC and Online Web Site Links

RCW/WAC Links

Uniform Disciplinary Act..... UDA RCW 18.130

Administrative Procedure Act ..... APA RCW 34.05

Administrative procedures and requirements ..... WAC 246-12

Mental Health Counselor Laws..... RCW 18.225

Mental Health Counselor Rules..... WAC 246-809

Standards of Professional Conduct WAC..... WAC 246-16

On-Line

AIDS Training Resources ..... Reference Page

Mental Health Counselor Associate ..... Web Page

List-Serv

To receive emails regarding important mental health counselor professional information, please join our interested parties at ..... Listserv